Hinsdale Sport & Spine Therapy, Ltd.

1 E. Oak Hill Drive
Suite 400, Penthouse
Westmont, IL 60559
(p)630.455.1723
(f)630.455.1865

Patient Information							
Name: Last	First	MI	Social Sec #	Sex	Marital Status	Age	Date of Birth
					☐Single ☐Married		
Street Address	City	State	Zip	Home Phone	Cell Phone	Preferred Contact	
						☐Home ☐Cell	
Employer	Employment Status	Emergency Contact Name			Phone		
	☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed						
Spouse or Legal Guardian	Address	City	State	Phone	Relationship		
Referring Physician	Primary Care Physician	Do You want us to send reports to primary care physician?					
		☐ Yes ☐ No					
Primary Insurance	Secondary Insurance	Primary Insured Name	Date of Birth				

Financial Policy and Authorization of Treatment

Financial Policy

- Hinsdale Sport and Spine Therapy, Ltd will attempt to verify insurance benefits with your company and inform you of your benefits. This is not a guarantee of payment form your insurance.
- As a courtesy to our patients, we will file insurance claims on your behalf.
- You will be responsible to pay Copays and Co-Insurance

HIPAA

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Authorization to Release information

I hereby authorize Hinsdale Sport and Spine Therapy, Ltd. To release as required, such medical and other information pertaining in to this incidence of care to insurance companies, employer groups, and other health plans for the purpose of reimbursement for service rendered.

Assignment of Benefits

I hereby authorize Hinsdale Sport and Spine Therapy, Ltd. Upon agreement, to accept this assignment with my rights and claims for reimbursement for expenses allowable under Medicare, Medicaid, and any other health plan.

Treatment Authorization

Your signature is required below to authorize treatment, release information, and assign benefits to process your insurance claims. Signature also signifies that you have read the HIPAA Information Form and are in agreement to the terms.

Signature:_____ Date: _____

Guardian Signature (Under 18)_____ Date:_____